MEDICAL RECORD	Authorization for the Release of Medical Information

INSTRUCTIONS: Complete this form in its entirety and forward the original to the address below:

NATIONAL INSTITUTES OF HEALTH
MEDICAL RECORD DEPARTMENT
ATTN: MEDICOLEGAL SECTION
10 CENTER DRIVE, ROOM 1N208
MSC1192
BETHESDA, MD 20892-1192

TELEPHONE: (301) 496-3331
FACSIMILE: (301) 480-9982

IDENTIFYING INFORMATION:

Patient Name	Daytime Telephone	Date of Birth

REQUEST INFORMATION: Information is to be released to the following individual or party:

Name	Telephone

Address

The purpose or need for disclosure (charges will be determined based on purpose of disclosure):

Date Range of Information to be Released: from _____ to _____

Please check specific information to be released:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Reports
- ☐ Outpatient Progress Notes
- ☐ Length of Stay Verification
- ☐ Radiology Reports
- ☐ Radiology Films
- ☐ Tissue Exam Reports
- ☐ Tissue Slides
- ☐ Lab Results
- ☐ EKG Reports
- ☐ Echocardiogram Reports
- ☐ Heart Diagnostic Reports
- ☐ Nuclear Medicine Reports
- ☐ Nuclear Medicine Scans
- ☐ Other (Please Specify): _____

AUTHORIZATION: Permission is hereby granted to the Warren Grant Magnuson Clinical Center to release medical information to the individual/organization as identified above.
(Note: submission of this form authorizes the release of the information specified within one year from date of signature.)

Patient/Authorized Signature	Print Name	Date

If other than patient, specify relationship: _____

Patient Identification	Authorization for the Release of Medical Information NIH-527 (02-01) P.A. 09-25-0099 File in Section 4: Correspondence